Medical History Questionnaire

Name: ______________________________ Today's Date: ______________

Address: ______________________________ Phone: ______________

______________________________ Birth Date: _____ / _____ / _____

Soc. Sec. #: _____ / ___ /_____ Occupation/School Grade: ______________ Last Eye Exam: ____ / ____ / ____

Name of Medical Doctor: ______________________________ Last Medical Exam: ____ / ____ / _____

Medical History

List any ***medications you currently take*** (including prescription, over-the-counter, home remedies, and eye drops):

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____

____

Do you have ***allergies to any medications?*** ” No ” Yes If YES, describe: ______________

____

Please circle ***all major illnesses*** you have had: diabetes / heart disease / high blood pressure / stroke / cancer / arthritis / lupus thyroid / migraines / asthma or emphysema / allergies / kidney disease Other (please list): ______________

____

List any ***major surgeries or injuries*** you have had (with the year if known): ______________

____

List any other medical conditions (such as pregnancy / nursing, etc.) or medical problems that we should know about:

____

Family History -- note any family history (parents, grandparents, siblings, children), living or deceased, for the following:

DISEASE / CONDITION	YES	NO	?	RELATIONSHIP TO PATIENT
Blindness	”	”	”	______________
Glaucoma	”	”	”	______________
Macular Degeneration	”	”	”	______________
Cancer	”	”	”	______________
Diabetes	”	”	”	______________
Heart Disease	”	”	”	______________
High Blood Pressure	”	”	”	______________
Thyroid Disease	”	”	”	______________
Other: ______________				______________

Social History

Do you drive? ” Yes ” No If YES, do you have any visual difficulty when driving? ” Yes ” No

Do you use tobacco products? ” Yes ” No If YES, list *type, amount, how long*: ______________

Do you drink alcohol? ” Yes ” No If YES, list *how much / how often*: ______________

Eye History

Please circle any ***eye conditions*** you have or have had: cataract / glaucoma / macular degeneration / diabetic eye disease retinal detachment / “crossed” eyes / lazy eye (amblyopia) / eye infections / color blindness Other (please list): ________________

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List any ***eye surgeries*** (including Laser) or ***serious eye injuries*** you have had (with the year if known):

____

____

Do you currently wear glasses? ” Yes ” No If YES, how old are your present glasses? __________________

Do you ***currently*** wear contact lenses? ” Yes ” No If NO, have you ever worn contacts? ” Yes ” No

If you currently wear contacts, how old are they? __________ What type are they? ______________________________

Review of Systems

Do you ***currently*** have any problems in the following areas?

EYES	**YES**	**NO**
Blurred Vision	”	”
Distorted Vision (halos, starbursts, etc.)	”	”
Loss of Side Vision	”	”
Double Vision	”	”
Floaters or Light Flashes	”	”
Glare / Light Sensitivity	”	”
Tired Eyes	”	”
Redness	”	”
Dryness	”	”
Itching	”	”
Burning or Stinging	”	”
Sandy or Gritty Feeling	”	”
Foreign Body Sensation	”	”
Eye Pain or Soreness	”	”
Excess Tearing / Watering	”	”
Mucous Discharge	”	”
ALLERGIC / IMMUNOLOGIC		
Hay Fever	”	”
Lupus	”	”
CARDIOVASCULAR		
Heart Disease	”	”
High Blood Pressure	”	”
Vascular Disease (blockage, etc.)	”	”
EARS, NOSE, MOUTH & THROAT		
Hearing Difficulty / Deafness	”	”
Sinus Congestion / Infection	”	”
Dry Mouth / Throat	”	”

ENDOCRINE	**YES**	**NO**
Diabetes	”	”
Thyroid Dysfunction	”	”
GASTROINTESTINAL		
Ulcer	”	”
Stomach / Intestinal Disease	”	”
GENITOURINARY		
Kidney Ailments	”	”
Sexually Transmitted Disease (STD)	”	”
HEMATOLOGIC (blood) / LYMPHATIC		
Anemia	”	”
High Cholesterol	”	”
INTEGUMENTARY (skin)		
Rosacea	”	”
Skin Cancer	”	”
MUSCLES / JOINTS / BONES		
Arthritis	”	”
NEUROLOGICAL		
Headaches / Migraines	”	”
Multiple Sclerosis	”	”
Epilepsy / Seizures	”	”
PSYCHIATRIC		
Anxiety Disorder	”	”
Depression	”	”
RESPIRATORY		
Asthma / Bronchitis / Emphysema	”	”
CONSTITUTIONAL		
Fever, Weight Gain / Loss	”	”

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

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Doctor’s Signature: ____ **Date:** ________________________